MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23-a

CERTIFICATE OF DEATH

*02737

Reg. Dist. No. 1000

1. PLACE OF DEATH:

County: Charles

City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 minutes

Hospital, Institution, or street address where death occurred:
Physicians Memorial Hospital

How long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Benedict
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: W or S WAR I

3.(a) FULL NAME: Wilmer F. Butler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: ANNIE Butler

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): MARCH 22 1895

8. AGE: Years	Months	Days	If less than one day
51 ~~52~~	11	13	hrs. min.

9. Birthplace: Charles Co.
(Town, county, and state)

10. Usual occupation: WATERMAN

11. Industry or business: Oystering & Fishing

FATHER
12. Name: John F Butler
13. Birthplace: Charles Co Md

MOTHER
14. Maiden name: SARAH Thomas
15. Birthplace: Charles Co - Md

16. Informant: ANNIE Butler (Wife)
Address: Benedict Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-11-47 (month) (day) (year)
Cemetery or crematory: ARLINGTON NAT'L CEMETERY
Location: ARLINGTON VA.

18. Funeral director: ELMER M. Quade
Address: Hughesville - Md

19. 3-10 (Date rec'd by registrar) 19 47 Julia H. Poe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 19 47 at 6:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7, 19 47 to 19; and that I last saw him alive on March 7, 19 47

Immediate cause of death	DURATION
Cerebral hemorrhage	4 hrs.
Due to: Essential hypertension	10 yrs.
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jas. L. MacKavanagh M.D.
M.D. or other

Address: La Plata, Md. Date signed: 3-7-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170c

02738

Reg. Dist. No. 1004

1. PLACE OF DEATH:

County: Charles

City or town: mr. Pisgah
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
State rd. Md. 484

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: mr. Pisgah
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Columbus J. Collins, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 15, 1910

8. AGE: Years: 35 | Months: 9 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: McConchie md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

MOTHER FATHER

12. Name: Columbus Collins

13. Birthplace: La Plata, md

14. Maiden name: Cora Gillen

15. Birthplace: La Plata, md

16. Informant: Columbus Collins

Address: McConchie, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/2/47 (month) (day) (year)

Cemetery or crematory

Location: McChondie, md.

18. Funeral director: Hunt & Ryon

Address: Waldorf, md.

19. 4-2-47 (Date rec'd by registrar) 19 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1947, at about 11 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on March 31, 1947, to 19; and that I last saw him alive on March 31, 1947

Immediate cause of death	DURATION
Crushed chest	Minutes
Due to: Auto accident	Minutes
Due to: Struck by hit-&-run driver	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 3-30-47

Where did injury occur? mr. Pisgah, (City or town) Charles, (County) Md. (State)

Injured at home, farm, industry, public place (where?): State road, Md 484

Means of injury: hit by auto Injured at work? No

23. SIGNATURE: John L. Mackenzie, M.D., Deputy Medical Examiner
M. D. or other

Address: La Plata, Md Date signed: 3-31-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

02739

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 101 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Charles

City or town: Pisgah

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Pisgah

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Marshall Dent.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Married

6.(b) Name of husband or wife: Mary V. Dent

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 4 1883

8. AGE:

Years	Months	Days	If less than one day
63	5	23	..... hrs. ..... min.

8. Birthplace: Charles Co. Md.

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Samuel Dent

13. Birthplace: Chas. Co. Md.

MOTHER

14. Maiden name: Mary Dent??

15. Birthplace: Charles Co. Md.

16. Informant: Laura Swann

Address: Chicamuxen Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 30 47 (month) (day) (year)

Cemetery or crematory: Little Zion

Location: Pell Mk. Md

18. Funeral director: Stanley Lemmon

Address: Mason Springs Md.

19. March 29 1947 (Date rec'd by registrar) Murry Smallwood Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1947, at 10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 1946 to March 1947 and that I last saw him alive on March 1947

Immediate cause of death	DURATION
Cerebral Apoplexy.	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geo. C. Bicknell M.D. M. D. or other

Address: Bryantown Md. Date signed: March 29 1947

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1000 — 02740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Dyer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: Gertrude Eyles Dyer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years: 52.54 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: La Plata, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Joseph Dyer
13. Birthplace: Chas. Co. Md.

MOTHER
14. Maiden name: Susan Watts
15. Birthplace: Chas. Co. Md.

16. Informant: Geo Watts
Address: La Plata, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/14/47 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: La Plata, Md.

18. Funeral director: Hunt & Ryon
Address: Waldorf, Md.

19. 3-13 1947 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11, 1947, at 7 00 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3, 1947, to March 11, 1947 and that I last saw him alive on March 3, 1947

Immediate cause of death	DURATION
Pulmonary tuberculosis	6-8 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: X Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James L. MacKaraugh, M.D.
M. D. or other
Address: La Plata, Md. Date signed 3-11-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

★ 12741

Reg. Dist. No. 106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years (winters only)
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: West Moreland
City or town: Oak Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME David Wolf Eston

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6.(b) Name of husband or wife: Nora L - Eston.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 7. 1862

8. AGE: Years 85 | Months | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace: Kittanning, Penna
(Town, county, and state)

10. Usual occupation: Civil Engineer (Retired)

11. Industry or business: U.S. Govt.

FATHER 12. Name: John Eston
FATHER 13. Birthplace: Kittaning Penna.

MOTHER 14. Maiden name: Jane Peart
MOTHER 15. Birthplace: Kittaning Penna

16. Informant: Mrs. Sue Eston West.
Address: Indian Head. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 9 (month) (day) 1947 (year)
Cemetery or crematory: Oak Grove Cemetery
Location: Oak Grove, Va

18. Funeral director: Hunt & Ryon
Address: Waldorf. Md.

19. 3/8 1947 (Date rec'd by registrar) Odey Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1947, at 8:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/15 1947 to 3/8 1947 and that I last saw h.l.m.alive on March 8 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	1 day
Due to:	
Due to:	
Other conditions: Diabetes Mellitus	8 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank G. Susano M.D. M. D. or other
Address: Indian Head. Md. Date signed 3/8/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bd)

CERTIFICATE OF DEATH

02742

Reg. Dist. No. 1060

1. PLACE OF DEATH:
County: Charles.
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Charles
City or town: Indian Head.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Fannie Chandler Jackson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: Frank Jackson.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 24 1870

8. AGE: Years	Months	Days	If less than one day
76	9	12	..... hrs. ..... min.

9. Birthplace: Charles County, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Samuel Todd Chandler.
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Jane Elizabeth Todd.
MOTHER 15. Birthplace: Virginia
16. Informant: Mrs. Richard Slavin
Address: Indian Head
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 9 1947 (month) (day) (year)
Cemetery or crematory: Durham Parish
Location: Ironsides, Md.
18. Funeral director: Hunt & Ryan
Address: Waldorf, Md.
19. Mar. 8 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1947, at 3 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23 1946 to March 6 1947
and that I last saw her alive on March 6 1947

Immediate cause of death	DURATION
Chronic Myocard. ds	2 years.
Due to	
Due to	
Other conditions: Pernicious Anemia	1 year.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank G. Susan M.D.
M. D. or other
Address: Indian Head, Md. Date signed: 3-6-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4-m

CERTIFICATE OF DEATH

02743

Reg. Dist. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: Bryantown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Bryantown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WILLIAM WATT JENKINS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lula A. Jenkins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 3 1873

8. AGE: Years	Months	Days	If less than one day
74	2	24	..... hrs. ..... min.

9. Birthplace: Charles Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Luther Jenkins

13. Birthplace: Charles Co., Md

MOTHER — 14. Maiden name: Mary Freeman

15. Birthplace: Charles Co. Md

16. Informant: Leo Jenkins

Address: Bryantown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-31-47 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Bryantown, Md.

18. Funeral director: Elmer M. Quade

Address: Hughesville, Md.

19. 3/28/47 (Date rec'd by registrar) Julia H. Pacy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 1947, at 5.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 March 1947, to 23 March 1947, and that I last saw him alive on the 23 March 1947

Immediate cause of death	DURATION
Heart Failure	
Due to (1) Aortic and Mitral Valve Insufficiency (2) Severe Anemia	
Due to Cancer of Gastro-Intestinal Tract,	
Other conditions Old tuberculous case	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Francis J. Culley M. D. or other

Address: Hughesville, Md Date signed: 3-28-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02744

Reg. Dist. No. 1000

1. PLACE OF DEATH:
County Charles
City or town La Plata
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Charles
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1503 Belt St.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Gustav Kroft

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1874

8. AGE:

Years	Months	Days	If less than one day
72	6	12	..... hrs. ..... min.

9. Birthplace Germany
(Town, county, and state)
10. Usual occupation Boiler Maker
11. Industry or business
FATHER 12. Name unknown
13. Birthplace "
MOTHER 14. Maiden name unknown
15. Birthplace "
16. Informant Mrs Louise Carey
Address 1503 Belt St. Baltimore, Md.
17. Burial Date thereof 3/3/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill
Location Brookland, Md.
18. Funeral director Hunt & Ryon
Address Waldorf, Md.
19. 3/1 19 47 Julia H. Posey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-1 19 47, at 5 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-28 19 47 to 3-1 19 47
and that I last saw h.i.m. alive on 2-28 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	3-1-47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. Hedelen M. D.
M. D. or other
Address La Plata, Md. Date signed 3-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

★ 02745

Reg. Dist. No. 106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County CHARLES

City or town INDIAN HEAD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 YEARS

Hospital, institution, or street address where death occurred:
12 EARL ROAD

How long in hospital or institution? 6 MONTHS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County CHARLES

City or town INDIAN HEAD
(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 EARL ROAD
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME GRACE V. LYNN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife WAYNE B. LYNN

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 2-3-92

8. AGE: Years	Months	Days	If less than one day
54	1	5	..... hrs. ..... min.

9. Birthplace ALEXANDRIA VIRGINIA
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER 12. Name CHARLES SCHREINER

13. Birthplace BALTIMORE MARYLAND

MOTHER 14. Maiden name STELLA HEISLEY

15. Birthplace ALEXANDRIA VA.

16. Informant H.C. MILLER

Address INDIAN, HEAD, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-9-47 (month) (day) (year)

Cemetery or ~~crematory~~ PRESBYTERIAN

Location WASH'T ALEXANDRIA, VA.

18. Funeral director CHAMBERS (517-11th St. S.E.)

Address WASHINGTON D.C.

19. March 8 1947 (Date rec'd by registrar) Odey Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-7 1947, at 1158 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-5 1947, to 3-7 1947 and that I last saw her alive on 3-7 1947

Immediate cause of death	DURATION
* METESTATIC CARCINOMA (RESPIRATORY ENCROACHMENT)	6 YEARS
Due to Primary carcinoma of breast. Rt. Metastatic spread to the lung tissues.	
Due to Also, cerebral metastases.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations CARCINOMA

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frederic W. Reichardt M.D.
M. D. or other

Address Indian Head Md. Date signed 3-8-47

2-35

Form V. S. No. 5—50M—7-8-24

MARYLAND

CERTIFICATE OF DEATH

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

02746

1. PLACE OF DEATH

County of Charles — Registration District No. .....

Township of ..... — File No. .....

or Borough of ..... — Primary Registration District No. .....

or City of Malcolm, Md. No. ....., ... St. ..... Ward) — Registered No. 105

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

2. FULL NAME Regina Greenfield Makle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	Col.	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) ? 1920

7. AGE	Years	Months	Days	IF LESS than 1 day, ...hrs. or ....min.
	27			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or towo) Malcolm, Md.
(State or country)

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12. MAIDEN NAME OF MOTHER Eva Greenfield

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Malcolm, Md.

14. Informant Lavina Greenfield
(Address) Malcolm, Md.

15. Filed 3-26, 1947 M L Moore
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 22 1947
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from, ..., 19....., to ....., 19 .....,
that I last saw h.. alive on Feb. 21, 1947
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:

Pulmonary & circulatory collapse due to Phthesis pulmonalis 2

(duration) 1 yrs. 2 mos. ? ds.

CONTRIBUTORY (SECONDARY) Emaciation & Anorexia (duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? ?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C K Lapin, M. D.
March 26 1947 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ St. Peter's, Waldorf, Md. — DATE OF BURIAL 3/26 1947

20. UNDERTAKER Hunt & Ryon — ADDRESS Waldorf, Md.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should he used only when needed. As examples: (a) *Spinner,* (h) *Cotton mill,* (a) *Salesman,* (b) *Grocery,* (a) *Foreman,* (b) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day Laborer, Farm laborer, Laborer—Coal mine etc.* Women at home who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife. Housework, or At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has heen changed or given up on account of tho DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from tusiness, that faet may be indicated thus: *Farmer (retired 6 ys.)* For persons who have no occupation whatever write *None.*

Statement of cause of death.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term of the same diseases. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup") *Typhoid fever* (never report "Typhoid-Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinitc); *Tuberculosis* of *lungs, meninges, peritonacum,* etc., *carcinoma, Sarcoma, etc.,* of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitia lnephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example. *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symtomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure." "Haemorrhage," "Inanition," "Marasmus," Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always quality as "PUERPERAL *septichaemia*" "PUERPERAL *peritionitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such if impossihle to determine definitely. Examples: *Accidental drowning: Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—Probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory."

Space for additional information by physician

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

02747

Reg. Dist. No. 106

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Indian Head Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Ellen Neale

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 26. 1947

8. AGE: Years | Months | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Indian Head Md
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: James E. Neale
13. Birthplace: La Plata, Md.

MOTHER
14. Maiden name: Wahneeta Johnson
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. James E. Neale
Address: La Plata, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 31, 1947 (month) (day) (year)
Cemetery or crematory: Sacred Heart
Location: La Plata Md

18. Funeral director: James E. Neale
Address: La Plata, Md

19. 3-31 1947 (Date rec'd by registrar) Ashley Pride Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1947, at 5:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Atelectasis	4 days
Due to	
Due to	
Other conditions: Prematurity	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Franklyn Swan M.D.
M. D. or other
Address: Indian Head Md Date signed 3/30/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

02748

Reg. Dist. No. 1000

1. PLACE OF DEATH:
County: Charles
City or town: Benedict
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Benedict
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George Vincent Parker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 24 1878

8. AGE: Years	Months	Days	If less than one day
68	3	20	..... hrs. ..... min.

9. Birthplace: Charles Co. Md (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Grocery Store
FATHER 12. Name: George V. Parker
13. Birthplace: Prince Geo. Co., Md
MOTHER 14. Maiden name: Sarah C. Roach
15. Birthplace: Charles Co. Md
16. Informant: Mary Joe Duke
Address: Benedict, Md,
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-17-47 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: Bryantown, Md
18. Funeral director: Elmer M. Quade
Address: Hughesville, Md
19. 3/16/47 (Date rec'd by registrar) 19..... Julia Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 14 47, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19 47, to March 14 19 47 and that I last saw h..m..alive on March 14 19 47

Immediate cause of death	DURATION
Pulmonary-Circulatory collapse (peripheral)	
Due to: Bilateral lung lesions	
Due to: Tuberculosis, pulmonary Bilateral	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Alfred R. Lapen, M.D. M. D. or other
Address: Aquasco, Md Date signed: March 15, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13a

02749

CERTIFICATE OF DEATH

Reg. Dist. No. 10 50

1. PLACE OF DEATH
County: Charles
City or town: White Plains md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: Chas
City or town: White Plains md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Florence Rabey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife: Julian
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 15 - 1871

8. AGE: Years: 75 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Chas Co Md
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: Clay Rabey
13. Birthplace: Chas Co Md

MOTHER
14. Maiden name: Mitchum
15. Birthplace

16. Informant: Mrs Pauline Perry
Address: White Plains Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 3-24-47 (month) (day) (year)
Cemetery or crematory: St Paul Priory
Location: Waldorf Md

18. Funeral director: Hamett & Posey
Address: Waldorf Md

19. 3-24 19 47 (Date rec'd by registrar) M L Moore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 19 47 at 10 A.M. (12)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 38 to 3/22 19 47 and that I last saw h.. alive on 3/22 19 47

Immediate cause of death	DURATION
Myocardial Apoplexy	
Due to: Cardio-Vascular Renal Disease	
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C. J. Weber M.D. M. D. or other
Address: Waldorf, Md Date signed 3/23/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

02750

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

Reg. Diat. No. 1000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Charles

City or town: Bryantown Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 + years

Hospital, institution, or street address where death occurred:

home

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Bryantown
(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME LOUIS HENRY STEFFENS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: MARIE

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): 6/2/91

8. AGE: Years	Months	Days	If less than one day
55	9	16	...hrs. ...min.

9. Birthplace: Duluth, Minnesota
(Town, county, and state)

10. Usual occupation: Surveyor

11. Industry or business

FATHER — 12. Name: DIETRICH H. STEFFENS

FATHER — 13. Birthplace: WHITESTONE LONG ISLAND, N.Y.

MOTHER — 14. Maiden name: MARIE A. STEFFENS

MOTHER — 15. Birthplace: GERMANY

16. Informant: SON. DIETRICH ~~[illegible]~~ H. STEFFENS

Address: BRYANTOWN, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-20-47 (month) (day) (year)

Cemetery or crematory: St Pauls Lutheran

Location: Chapel Hall

18. Funeral director: Hewitt & Dyson

Address: Waldorf Md

19. ...19... (Date rec'd by registrar) Permit issued by ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1947, at 1:45 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 1946, to March 17 1947 and that I last saw h...alive on March 17 1947

Immediate cause of death	DURATION
Generalized Carcinomatosis	
Uremia	
Due to: Malignant Melanoma	6 1/2 Mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Warren Jarboe, M.D.
M. D. or other

Address: La Plata Md Date signed 3/18/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02751

Reg. Dist. No. 1002

1. PLACE OF DEATH:
County: Charles
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Phys. Mem. Hosp. LaPlata Md.
How long in hospital or institution? 3-18-47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Chas.
City or town: Rural Deatsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: James Samuel Turner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Widowed

6.(b) Name of husband or wife: Ethel Jane Montgomery
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 11, 1867

8. AGE: Years 79 Months 9 Days 9 If less than one day: hrs. min.

9. Birthplace: Chas. Co Md.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Edward Turner
13. Birthplace: ?

MOTHER
14. Maiden name: Lomax
15. Birthplace: ?

16. Informant: James E. Raymond B. Turner
Address: 3015-5th St. SE + 1900 B St NE D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-22-47 (month) (day) (year)
Cemetery or crematory: Trinity
Location: Deatsville

18. Funeral director: Elmer Eric Quade
Address: Hughesville Md

19. 3/21/47 (Date rec'd by registrar) 19 47 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-20 19 47 at 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to 3-20 1947 and that I last saw him alive on 3-20 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	9-10-46
Due to: Hypertension	12-1-46
Due to:	3-10-47
Other conditions: Uremia	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E Wedelen M.D.
M. D. or other
Address: LaPlata Md Date signed 3-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02752

Reg. Dist. No. 1002

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ days

Hospital, institution, or street address where death occurred: Physicians Memorial Hospital

How long in hospital or institution? 2½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Dorchester

City or town: Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Guy W. Willey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Estella Phillips

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): 1894

8. AGE:

Years	Months	Days	If less than one day
53			...hrs. ...min.

9. Birthplace: Bishops Head, Md. (Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: Power Cranes

FATHER

12. Name: Lain Willey

13. Birthplace: Bishops Head, Md.

MOTHER

14. Maiden name: Ada Robinson

15. Birthplace: Bishops Head, Md.

16. Informant: Norman Willey (son)

Address: Cambridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/7/47 (month) (day) (year)

Cemetery or crematory

Location: Cambridge, Maryland

18. Funeral director: Hurst & Ryon

Address: Waldorf, Md.

19. 3/5/47 (Date rec'd by registrar) 19... Julia H. Vasey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4, 1947, at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on March 4, 1947, to ...19... and that I ~~last~~ saw ~~him~~ ~~alive~~ on March 4, 1947

Immediate cause of death	DURATION
Pulmonary edema & mediastinal shock (flutter)	20 hrs.
Due to: Crushed chest ~~Dorsal~~	2½ days
Due to: Auto accident	2½ days
Other conditions: Fracture left leg; mild intra-abdominal contusion.	2½ days

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 3-2-47

Where did injury occur? Newburg (City or town), Charles (County), Md. (State)

Injured at home, farm, industry, public place (where?): State Rd. 301

Means of injury: Car turned over Injured at work? No

23. SIGNATURE: Deputy Medical Examiner James F. MacKaracher, M.D. M. D. or other

Address: La Plata, Md. Date signed 3-4-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35